

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH**

**CLINICAL INCIDENT (EVENT) MANAGERIAL REVIEW FOR CATEGORIES 3- SUSPECTED SUICIDE OR 4 -SUICIDE ATTEMPT ON PG. 1 OF THE [CIR](#)**

Print or complete on a computer but do not save it on a computer or e-mail it. Keep only one copy of this report in an administrative file. Do not include it or reference it or related discussions with clinical risk management in the client's record.

Send pgs. 2/3 within 30 days of the clinical incident to DMH Clinical Risk Management, Los Angeles County Department of Mental Health, 550 S. Vermont Ave., 12th Floor, Los Angeles, CA 90020, Att: Mary Ann O'Donnell/Doris Benosa,

or by confidential FAX to 213-738-4646, Att: Clinical Risk Management, Contact Numbers: 213-637-4588/213-639-6326

Client Last Name:	Client First Name	Is #	Manager's Name:	Manager's Signature:	Event Date	Date submitted:
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**23. If item 16. on pg. 1 is "N," does the clinical record contain:**  
 A. The risks/benefits for the use of the medication(s)? Y  N  and, if applicable,  
 B. Documentation of a consultation with the furnishing supervisor if the medications were furnished by an N.P. Note: if either A. or B. Are "N", please complete C. and D. below.

C. The manager, supervising M.D. or furnishing supervisor has informed the M.D., D.O., N.P. of the required documentation as stated in the DMH guidelines for the use of the parameters, item #. 5. Y <input type="checkbox"/> N <input type="checkbox"/>	D. The M.D., D.O., N.P. has acknowledged the requirement and has agreed to comply with the requirement in the future. Y <input type="checkbox"/> N <input type="checkbox"/> If N, attach explanation.
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**24. What was the method used? Describe, include information from coroner or other sources as available.**

**25. Was the client discharged from an inpatient facility within the last 30 days?** Y  N   
 A. If Y, enter facility name, discharge date and reason for admission.  
 B. If yes, enter date and type of first appointment post discharge.

**26. Was suicide risk assessed during the treatment episode?** Y  N   
 A. If Y, was a standardized risk assessment tool ever used? Y  N   
 B. If 26. A. is Y, specify name of standardized risk assessment tool and attach a copy:  
 C. If 26. A. is N, check which non-standardized method below was used:  
 Non-standard tool (attach copy)  Other (Specify type of assessment and what questions were asked or are typically asked.)  
 D. If 26. is Y, specify the date of the most recent suicide risk assessment:  
 E. If 26. Is N, specify the reason:

**27. Was client determined to be at risk for suicide?** Y  N   
 A. If Y, describe the interventions and follow-up actions, including a plan for safety and dates.

**28. Was a history of previous suicide attempts assessed?** Y  N   
 A. If Y, specify date(s), nature of attempt(s) and outcome, including hospitalizations:  
 B. If N, specify reason:

**29. Was a family history of suicide assessed?** Y  N   
 A. If Y, specify date(s), relationship of family member(s) and nature of suicide(s)  
 B. If N, specify reason:

**30. Describe the client's treatment course:** A. Duration of service:  
 B. Type(s) of services provided:  
 C. Frequency of services:

**CLINICAL INCIDENT (EVENT) SUPPLEMENTAL MANAGERIAL REVIEW FOR SUSPECTED SUICIDE OR SUICIDE ATTEMPT**

Client Last Name: \_\_\_\_\_ IS#: \_\_\_\_\_

<p><b>31. What were the documented goals of treatment?</b></p>
<p><b>32. What was the client's response to treatment for each goal?</b></p>
<p><b>33. Was the client was sufficiently engaged in treatment for managing the documented suicide risk? Y <input type="checkbox"/> N <input type="checkbox"/></b></p> <p>A. Did the client keep appointments? Y <input type="checkbox"/> N <input type="checkbox"/> If N, explain, include interventions if any.</p> <p>B. Did the client refuse any treatment recommendations or was he/she requesting only a specific service, e.g. meds only? Y <input type="checkbox"/> N <input type="checkbox"/> If Y, specify, include interventions if any:</p> <p>C. Were there other signs of lack of engagement? Y <input type="checkbox"/> N <input type="checkbox"/> If Y, specify, include interventions if any:</p>
<p><b>34. Were any acute stressors identified immediately prior to the suicide? Y <input type="checkbox"/> N <input type="checkbox"/></b></p> <p>A. If Y, specify.</p>
<p><b>35. If substances were a factor in the suicide/ attempt, was the client receiving co-occurring substance abuse treatment? Y <input type="checkbox"/> N <input type="checkbox"/> Not Applicable <input type="checkbox"/></b></p> <p>A. If N, why not?</p>
<p><b>36. What is your assessment of contributing factors and/or stressors?</b></p>
<p><b>37. What is the remedy or corrective action plan to reduce the likelihood for the recurrence of a similar event?</b></p>